MDR Tracking Number: M5-05-0948-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-19-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 11-17-03 and 11-18-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, chiropractic manipulative therapy, manual therapy techniques, electrical stimulation-unattended, and therapeutic ultrasound from 11-19-03 through 7-8-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-08-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT code 99213 – the requestor states that the MAR is $48.00. However, it is $61.98. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). Therefore, the requestor will be reimbursed $48.00 in all instances for which reimbursement is recommended.

Regarding CPT code 98942-25 – the requestor states that the MAR is $48.00. However, it is $57.35. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). Therefore, the requestor will be reimbursed $48.00 in all instances for which reimbursement is recommended

Neither the carrier nor the requestor provided EOB's for CPT codes 99213, 98943, G0283 (2 units), 97035 (2 units), or 97140-59 (2 units) for date of service **12-3-03**. However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $174.30**

Neither the carrier nor the requestor provided EOB's for CPT codes 99213, 98943, G0283 (2 units), 97035 (2 units), or 97140-59 (2 units) for date of service **12-22-03.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $174.30**

Neither the carrier nor the requestor provided EOB's for CPT codes 99213, 98943, G0283 (2 units), 97035 (2 units), or 97140-59 (2 units) for date of service **12-23-03.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $174.30**

Neither the carrier nor the requestor provided EOB's for CPT codes 99213, 98943, G0283 (2 units), 97035 (2 units), or 97140-59 (2 units) for date of service **12-24-03.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $174.30**

Neither the carrier nor the requestor provided EOB's for CPT codes 99213 or G0283 (2 units) for date of service **12-30-03.** However,

review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $74.82.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units), 97035 (2 units) or 97140-59 (2 units) for date of service **1-16-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $180.70.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units), 97035 (2 units) or 97140-59 (2 units) for date of service **2-9-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $180.70.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units), 97112 or 97140-59 (2 units) for date of service **3-5-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $178.98.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, G0283 (2 units), 97112 or 97140-59 (2 units) for date of service **3-8-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $172.58.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units), 97112 (2 units) or 97140-59 (2 units) for date of service **3-11-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor

reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $213.28.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 for date of service **3-25-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $112.95.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 for date of service **4-1-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $112.95.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 for date of service **4-19-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $112.95.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 (2 units) for date of service **6-15-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 for date of service **6-29-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $112.95.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59(2 units) for date of

service **7-1-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 (2 units) for date of service **7-6-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 (2 units) for date of service **7-15-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 (2 units) for date of service **7-20-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 (2 units) for date of service **7-27-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 (2 units) for date of service **8-3-04.** However, review of the reconsideration HCFAs and

documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 (2 units) for date of service **8-10-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, 97112 or 97140-59 (2 units) for date of service **8-17-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $152.10.**

Neither the carrier nor the requestor provided EOB's for CPT codes 98942-25, 98943, G0283 (2 units) or 97140-59 (2 units) for date of service **8-19-04.** However, review of the reconsideration HCFAs and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $144.68.**

Regarding CPT code 98942-25 for dates of service 1-13-04, 1-14-04, 1-15-04, 1-19-04, 1-21-04, 1-22-04, 1-26-04, 1-27-04, 1-28-04, 2-2-04, 2-5-04, 2-12-04, 2-16-04, 2-19-04, 2-23-04, 2-26-04, 3-1-04, 3-5-04, 3-16-04, 3-18-04, 3-23-04, 4-8-03, 4-13-03, 4-15-04, 4-22-04, 4-26-04, 5-4-04, 5-6-04, 5-11-04, 5-18-04, 5-20-04, 5-27-04, 6-1-04, 6-8-04, 6-10-04, 6-22-04, 6-24-04, 7-8-04 and 7-13-04: Neither the carrier nor the requestor provided EOB's for this service. However, review of the reconsideration HCFA's and documents submitted by the requestor reflected proof of billing in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $1,872.00. (39 x $48.00).**

This Finding and Decision is hereby issued this 4th day of January 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 12-3-03 through 8-19-04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 4th day of January 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

RL:da

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-0948-01
Name of Patient:	
Name of URA/Payer:	Connie Grass, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Charles E. George, MD

December 27, 2004

An independent review of the above-referenced case has been completed by chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY
Items Reviewed:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Statement of Medical Necessity/Reconsideration from treating doctor
3. Daily treatment notes from treating doctor
4. Imaging study reports
5. Referral doctors' notes/narratives
6. TWCC-73s
7. Notes from private counseling sessions, multidisciplinary pain group therapy notes, functional assessment report
8. Outpatient testing orders/notes (St. Elizabeth Hospital)
9. Peer reviews

Patient is a 47-year-old scrub tech who, on ____, picked up a tray of instruments to load onto the side of the cart and felt immediate sharp lower back and right leg pain that caused her to fall to the floor. After a several month trial of conservative care, she eventually underwent lumbar spine laminectomy on 08/10/2001, followed by post-operative physical therapy and rehabilitation. She experienced one flare-up in December of 2001, but despite this, was eventually released to return to work full-time on 04/23/2002. The records indicated that the patient was seen by a designated doctor on 02/28/2002, who determined she was at MMI with a 5% whole-person impairment. The chiropractic daily treatment notes that were submitted for review resume again in the summer of 2003.

REQUESTED SERVICE(S)
Office visits (99213), chiropractic manipulative therapy (98943), manual therapy techniques (97140-59), electrical stimulation, unattended (G0283), and therapeutic ultrasound (97035) for dates of service 11/19/03 through 07/08/04.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
According to the daily treatment notes submitted by the treating doctor of chiropractic, the same unchanging treatment plan had been tried and failed for months before these dates in dispute even began. Granted, physical medicine is an accepted part of a rehabilitation program following an injury, but for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. In general, expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. However in this case, the records failed to demonstrate that these occurred.

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains. In this case, there was no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. Put another way, there was no documentation or supporting evidence to demonstrate that the treatments provided resulted

in any significant continuing benefit, so there was no basis to continue a therapy that did not provide significant benefit. Expectation of functional restoration was not reasonable based on prior lack of success, and should have been discontinued.

Furthermore, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* [1] Chapter 8 under "Failure to Meet Treatment/Care Objectives" state that "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." As well, the ACOEM Guidelines[2] state that if manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated.

Insofar as the office visits (99213) were concerned, the services in question were after 08/01/2003 when it was no longer necessary to report spinal manipulation as an Evaluation and Management (E/M) procedure ("99213-MP"). Rather, it was appropriate (when was performed) to report it as a chiropractic spinal manipulative therapy (or "CMT") whenever it was performed, and in this case, the records and the EOBs clearly indicated that a multi-level chiropractic manipulative therapy service (98942-25) had already been reported on every patient encounter. Therefore, since CMT had already been reported, according to CPT [3], there was no support for the medical necessity of performing this level of E/M service (99213) on each and every visit, and particularly not during an already-established treatment plan.

And finally, most computerized documentation, regardless of the specific software utilized, fails to provide the individualized information necessary to justify medical necessity and warrant continued treatment. The Centers for Medicare and Medicaid Services (CMS) has

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[1] Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.

[2] *ACOEM Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition*, p. 299.

[3] *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

stated, "Documentation should detail the specific elements of the chiropractic service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information will be denied." [emphasis added] In this case, there was insufficient documentation to support the medical necessity for the treatment in question, since the computer-generated daily progress notes were essentially identical for each date of service.